by a letter inciting others to inflammatory correspondence." When, after 20 years' membership of the IMLS, I deemed it necessary to criticise the education policy (*IMLS Gazette*, April 1974) I was told that "sweeping and incorrect statements are not justified by emotive language."

The Scottish delegates who attended a recent IMLS symposium in Dundee certainly found no reassurance about this controversy from the president-elect, who seemed unwilling to admit that problems exist. May I reassure Dr W A J Crane and his colleagues (12 February, p 441) that many members of the IMLS, including chief technicians from district hospitals, disagree with the official dogma? Care of the sick is a team effort and verbatim quoting of Whitley Council regulations (PTB 273) is not required to remind myself or my colleagues that ultimate medical responsibility for laboratory investigations on our 1500 patients plus the GP service, health centres, etc, rests with the senior consultant and his four colleagues.

At the moment it would seem that the IMLS is unwilling to clarify further the statement of its aims in the light of recent correspondence and is content to write broad statements suggesting that a letter containing soundly based comment is an incitement to mutiny. It is to be hoped that our medical colleagues realise that there is a bigger reserve of goodwill among the technical staff than is apparent from official pronouncements.

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repetitive role as an educator of junior staff or a "clinical fire alarm." Discussion on possible developments in training can be found in the published reports of the first meeting.^{1,2} A time of clinical responsibility in specified fields is an important part of training for the clinical pathologist. Prospective clinicians would also undoubtedly benefit from time spent within the laboratory. The setting up of laboratory-clinical rotations could be an important advance and should be encouraged at both local and national levels.

The decline in recruitment to chemical pathology² and microbiology brings with it the prospect that senior posts will become altered to posts for non-medical graduates in default of medical applicants. We believe a medical influence, properly trained both scientifically and clinically, is vital within the laboratory and should successfully complement the work of the non-medical scientist.

The initiative which led to interchangeable primary qualifications between the MRCP and MRCPATH examinations has not been enough. We would like to suggest that an open working party be set up by the Royal College of Pathologists, involving the other royal colleges, to consider the steps needed to improve and encourage an appropriately integrated training. An improvement in recruitment would surely follow.

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¹ *Lancet*, 1976, 2, 945.

² Association of Clinical Biochemists Ltd, *News Sheet*, March 1977.

* * * This correspondence is now closed.—ED,
BMJ.

Laparoscopic sterilisation with Silastic bands

SIR,—Experience in Wolverhampton confirms the findings of Mr A A Templeton and his colleagues (16 April, p 1008) that laparoscopic sterilisation with Silastic bands is a useful technique and probably safer than laparoscopic tubal diathermy. During the past five years two patients sustained burns of the small intestine during tubal diathermy. Regrettably one died, but the other was rescued by timely laparotomy and bowel resection. The Silastic band technique also carries some risk.

Recently a 29-year-old woman who had previously had her gall bladder removed underwent laparoscopy and the application of Silastic bands. The applicator was inserted through a separate canula. No obvious difficulty was encountered and there were no pelvic adhesions. Twenty days later she was readmitted with a painful, tender mass in the left iliac fossa. A moderate neutrophilia was associated with a raised erythrocyte sedimentation rate (73 mm in the first hour). At laparotomy an abscess was found bounded by the left tube, ovary, and pelvic colon. The left ovary and both tubes were excised. Previous damage to the bowel wall was suspected so that a corrugated drain was inserted down towards the pelvic colon and the abdomen closed. Histological examination showed acute inflammation of the walls of the left tube and ovary, while the right tube was chronically inflamed. *Escherichia coli* was cultured from the pus. By the 35th day there was an obvious small faecal fistula in the left iliac fossa. The fistula was confirmed by barium enema, which also excluded other disease of the large bowel. The fistula has

since closed slowly, and the patient only regained normal health five months after the first operation.

It is probable that the pelvic colon was pierced by the Verres needle or one of the two trocars used. It is unlikely that the pelvic colon was injured by either the Silastic band applicator or the ring itself, but the exact way in which the bowel was damaged remains unknown.

I thank Mr H J Fisher for access to the records of his patients.

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Swimming goggles causing severe eye injuries

SIR,—With reference to the report by Dr F Jónasson of three cases of severe ocular trauma caused by swimming goggles (2 April, p 881) I wish to report a similar case.

A 3-year-old boy was hit in the left eye by a swimming goggle. He presented to this department three days later, on returning from holiday, complaining of a sore eye. He had had no treatment before his hospital visit. Examination revealed a large penetrating corneal laceration of the left eye with prolapse of the iris. He had only perception of light in that eye.

The laceration was repaired, excising the necrotic iris. Careful examination under anaesthesia also revealed moderate commotio retinae near the macula and suspected anterior lens capsule damage. The eye subsequently healed uneventfully, but on removal of the corneal sutures three weeks later a sectorial cataract had developed across the visual axis.

Not only is future visual impairment inevitable from the injury but the probability of amblyopia in such a young child is high. I can only reiterate the sentiments of Dr Jónasson about redesigning the type of strap used for swimming goggles.

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Disseminated histoplasmosis in Britain

SIR,—In the case of the patient described by Dr A Jariwalla and his colleagues (16 April, p 1002), a diagnosis of disseminated histoplasmosis was made from the histological appearances of biopsy sections of the oral ulcer and the presence of hepatosplenomegaly. Several aspects of this report warrant comment.

The authors have failed to realise that this form of histoplasmosis in the United Kingdom was well described by Symmers.¹ All 48 cases in Symmers's series were in White Europeans who had been in southern or south-eastern Asia for periods of a year or more. Their illnesses developed overseas or up to 33 years after their return to Europe. Men outnumbered women by about three to one. The clinical picture was distinctive, being characterised by painful ulceration of mucocutaneous junctions or mucosae near bodily orifices. A second feature of this form of histoplasmosis is acute adrenal cortical insufficiency, responsible for 11 of the 23 deaths in Symmers's series.

It should be made clear that the expertise required for recognising *Histoplasma capsulatum* in tissue sections is readily available on

SIR,—Your leading article (2 April, p 866) emphasises the importance of the medically qualified graduate within the laboratory. Professor L G Whitby and his colleagues (23 April, p 1082) tend to blur the distinction between the medical and non-medical graduate. We would argue that they have complementary roles, but the difference needs to be more clearly defined. As trainee pathologists we view with concern the decline of recruitment of the medical graduate to pathology and consider there is a need for a reappraisal of the role and training of the clinical pathologist which fully justifies his medical training and the importance this has to the laboratory.

The advances made in haematology by correlation of laboratory and clinical expertise are now well known. Poor recruitment to the other branches of pathology is occurring just at the time when the rapid and sophisticated development of these services requires a strong laboratory-clinical interface. There is a continuing need for the central influence of the medical graduate in the direction of development, the monitoring of the usefulness of new technical advances, and the control of the soaring work load.

Recently two meetings of trainees in chemical pathology have discussed training; last October in Cambridge and this March at the Royal College of Pathologists. Two major frustrations were, firstly, the failure to clarify the overlapping roles of the medical and non-medical graduate; secondly, the similar failure to define the clinical role and responsibility of the medical graduate. This may relegate him, if the contact is too superficial, to being a "textbook physician" or, if the responsibilities are too many, restrict him to a